

SERIAL 01178 RFP EMPLOYEE HEALTH BENEFITS PLAN

DATE OF LAST REVISION: September 23, 2005 CONTRACT END DATE: June 30, 2007

JUNE 30, 2007
~~DECEMBER 31, 2005~~
~~DECEMBER 31, 2004~~
CONTRACT PERIOD THROUGH DECEMBER 31, 2003

TO: All Departments

FROM: Department of Materials Management

SUBJECT: Contract for **EMPLOYEE HEALTH BENEFITS PLAN**

Attached to this letter is published an effective purchasing contract for products and/or services to be supplied to Maricopa County activities as awarded by Maricopa County on **January 01, 2003**.

All purchases of products and/or services listed on the attached pages of this letter are to be obtained from the vendor holding the contract. Individuals are responsible to the vendor for purchases made outside of contracts. The contract period is indicated above.

Wes Baysinger, Director
Materials Management

SD/mm
Attach

Copy to: Clerk of the Board
Mike Schaiberger, **Total Compensation**
Pat Vancil, **Total Compensation**
Diane Golat, **Total Compensation**
Sharon Tohtsoni, Materials Management

(Please remove Serial 97025-MS from your contract notebooks)



CONTRACT FOR SERVICES PURSUANT TO RFP

SERIAL 01178-RFP

This Contract is entered into this 19th day of August, 2002 by and between Maricopa County ("County"), a political subdivision of the State of Arizona, and United Behavioral Health, an California corporation ("Contractor") for the purchase of Behavioral Health Care Services.

1.0 TERM

- 1.1 This Contract is for a term of one (1) year, beginning on the 1st day of January 2003 and ending the 31st day of December ~~2003 2004 2005~~ **June 30, 2007**.
- 1.2 The County may, at its option and with the agreement of the Contractor, extend the period of this Contract for additional one (1) year terms up to a maximum of Nine (9) additional terms. The County shall notify the Contractor in writing of its intent to extend the Contract period at least one hundred and twenty (120) calendar days prior to the expiration of the original contract period, or any additional term thereafter.

2.0 PAYMENT

- 2.1 As consideration for performance of the duties described herein, County shall pay Contractor the sum stated in Final Pricing, attached hereto and incorporated herein as Exhibit "A"
- 2.2 Payment under this Contract shall be made in the manner provided by law. Invoices shall contain the following information: description of services, quantities, unit prices, and extended totals and applicable sales/use tax. The County is not subject to excise tax.
- 2.3 County shall not be responsible to contractor for mistakes discovered after ninety (90) days.

3.0 DUTIES

- 3.1 The Contractor shall perform all duties stated in the Agreed Scope of Work, attached hereto and incorporated herein as "Exhibit B, Exhibit B 1 (Best and Final Clarifications), Exhibit B 2 (Application), Exhibit B 3 (Product Schedule) and Exhibit B 4 (Amendment to Policy).

4.0 TERMS & CONDITIONS

4.1 INDEMNIFICATION AND INSURANCE:

4.1.1 Indemnification.

To the fullest extent permitted by law, Contractor shall defend, indemnify, and hold harmless the County, its agents, representatives, officers, directors, officials, and employees from and against all claims, damages, losses and expenses, including but not limited to attorney fees and costs, relating to this Contract.

The amount and type of insurance coverage requirements set forth herein will in no way be construed as limiting the scope of the indemnity in this paragraph.

The scope of this indemnification does not extend to the negligence of the County.

4.1.2 Insurance Requirements.

Contractor, at its own expense, shall purchase and maintain the herein stipulated minimum insurance with companies duly licensed, possessing a current A.M. Best, Inc. Rating of B++6, or approved unlicensed companies in the State of Arizona with policies and forms satisfactory to the County.

All insurance required herein shall be maintained in full force and effect until all work or service required to be performed under the terms of the Contract is satisfactorily completed and formally accepted. Failure to do so may, at the sole discretion of the County, constitute a material breach of this Contract.

The Contractor's insurance shall be primary insurance as respects the County, and any insurance or self-insurance maintained by the County shall not contribute to it.

Any failure to comply with the claim reporting provisions of the insurance policies or any breach of an insurance policy warranty shall not affect coverage afforded under the insurance policies to protect the County.

The Contractor shall be solely responsible for the deductible and/or self-insured retention and the County, at its option, may require the Contractor to secure payment of such deductibles or self-insured retentions by a surety bond or an irrevocable and unconditional letter of credit.

The County reserves the right to request and to receive, within ten (10) working days, certified copies of any or all of the herein required insurance policies and/or endorsements. The County shall not be obligated, however, to review such policies and/or endorsements or to advise Contractor of any deficiencies in such policies and endorsements, and such receipt shall not relieve Contractor from, or be deemed a waiver of the County's right to insist on strict fulfillment of Contractor's obligations under this Contract.

The insurance policies required by this Contract, except Workers' Compensation, shall name the County, its agents, representatives, officers, directors, officials and employees as Additional Insureds.

The insurance policies required hereunder, except Workers' Compensation, shall contain a waiver of transfer of rights of recovery (subrogation) against the County, its agents, representatives, officers, directors, officials and employees for any claims arising out of Contractor's work or service.

4.1.2.1 Commercial General Liability. Contractor shall maintain Commercial General Liability insurance with a limit of not less than \$1,000,000 for each occurrence with a \$2,000,000 Products/Completed Operations Aggregate and a \$2,000,000 General Aggregate Limit. The policy shall include coverage for bodily injury, broad form property damage, personal injury, products and completed operations and blanket contractual coverage including, but not limited to, the liability assumed under the indemnification provisions of this Contract which coverage will be at least as broad as Insurance Service Office, Inc. Policy Form CG 00 01 10 93 or any replacements thereof.

The policy shall contain a severability of interest provision, and shall not contain a sunset provision or commutation clause, or any provision which would serve to limit third party action over claims.

The Commercial General Liability additional insured endorsement shall be at least as broad as the Insurance Service Office, Inc.'s Additional Insured, Form CG 20 10 11 85, and shall include coverage for Contractor's operations and products and completed operations.

If the Contractor subcontracts any part of the work, services or operations awarded to the Contractor, Contractor shall purchase and maintain, at all times during prosecution of the work, services or operations under this Contract, an Owner's and Contractor's Protective Liability insurance policy for bodily injury and property damage, including death, which may arise in the performance of the Contractor's work, service or operations under this Contract. Coverage shall be on an occurrence basis with a limit not less than \$1,000,000 per occurrence, and the policy shall be issued by the same insurance company that issues the Contractor's Commercial General Liability insurance.

4.1.2.2 Automobile Liability. Contractor shall maintain Automobile Liability insurance with an individual single limit for bodily injury and property damage of no less than \$1,000,000, each occurrence, with respect to Contractor's vehicles (whether owned, hired, non-owned), assigned to or used in the performance of this Contract.

4.1.2.3 Workers' Compensation. The Contractor shall carry Workers' Compensation insurance to cover obligations imposed by federal and state statutes having jurisdiction of Contractor's employees engaged in the performance of the work or services, as well as Employer's Liability insurance of not less than \$1,000,000 for each accident, \$1,000,000 disease for each employee, and \$1,000,000 disease policy limit.

If any work is subcontracted, the Contractor will require Subcontractor to provide Workers' Compensation and Employer's Liability insurance to at least the same extent as required of the Contractor.

4.1.3 Certificates of Insurance.

4.1.3.2 Prior to commencing work or services under this Contract, Contractor shall furnish the County with certificates of insurance, or formal endorsements as required by the Contract in the form provided by the County, issued by Contractor's insurer(s), as evidence that policies providing the required coverage, conditions and limits required by this Contract are in full force and effect. Such certificates shall identify this contract number and title.

In the event any insurance policy (ies) required by this Contract is (are) written on a "claims made" basis, coverage shall extend for two years past completion and acceptance of the Contractor's work or services and as evidenced by annual Certificates of Insurance.

If a policy does expire during the life of the Contract, a renewal certificate must be sent to the County fifteen (15) days prior to the expiration date.

4.1.4 Cancellation and Expiration Notice.

Insurance required herein shall not be permitted to expire, be canceled, or materially changed without thirty- (30) day's prior written notice to the County.

4.2 NOTICES:

All notices given pursuant to the terms of this Contract shall be addressed to:

For County:

Maricopa County
Department of Materials Management
Attn: Director of Purchasing
320 West Lincoln Street
Phoenix, Arizona

For Contractor:

United Behavioral Health
425 Market Street, 27th Floor
San Francisco, CA. 94105-2426

Attn: Executive Vice President & COO

4.3 ESCALATION:

Any requests for reasonable price adjustments must be submitted two hundred and ten (210) days prior to the then Contract period's expiration date. Requests for adjustment in must be supported by appropriate documentation. The **Not to Exceed** cap on the following years rates are due the first of January of the year preceding. If County agrees to the adjusted rates, County shall issue written approval of the change. The reasonableness of the request will be determined by the claims experience and/or by performing a market survey.

4.4 TERMINATION:

County may unconditionally terminate this Contract for convenience by providing thirty (30) calendar days advance notice to the Contractor.

County may terminate this Contract if Contractor fails to pay any charge when due or fails to perform or observe any other material term or condition of the Contract, and such failure continues for more than ten (10) days after receipt of written notice of such failure from County, or if Contractor becomes insolvent or generally fails to pay its debts as they mature.

4.5 STATUTORY RIGHT OF CANCELLATION FOR CONFLICT OF INTEREST:

Notice is given that pursuant to A.R.S. § 38-511 the County may cancel this Contract without penalty or further obligation within three years after execution of the contract, if any person significantly involved in initiating, negotiating, securing, drafting or creating the contract on behalf of the County is at any time while the Contract or any extension of the Contract is in effect, an employee or agent of any other party to the Contract in any capacity or consultant to any other party of the Contract with respect to the subject matter of the Contract. Additionally, pursuant to A.R.S § 38-511 the County may recoup any fee or commission paid or due to any person significantly involved in initiating, negotiating, securing, drafting or creating the contract on behalf of the County from any other party to the contract arising as the result of the Contract.

4.6 OFFSET FOR DAMAGES;

In addition to all other remedies at law or equity, the County may offset from any money due to the Contractor any amounts Contractor owes to the County for damages resulting from breach or deficiencies in performance under this contract.

4.7 ADDITIONS/DELETIONS OF SERVICE:

The County reserves the right to add and/or delete products and/or services provided under this Contract. If a requirement is deleted, payment to the Contractor will be reduced proportionately to the amount of service reduced in accordance with the bid price. If additional services and/or products are required from this Contract, prices for such additions will be negotiated between the Contractor and the County.

4.8 SUBCONTRACTING:

The Contractor may not assign this Contract or subcontract to another party for performance of the terms and conditions hereof without the written consent of the County, which shall not be unreasonably withheld. All correspondence authorizing subcontracting must reference the Bid Serial Number and identify the job project.

4.9 AMENDMENTS:

All amendments to this Contract must be in writing and signed by both parties.

4.10 RETENTION OF RECORDS:

The Contractor agrees to retain all financial books, records, and other documents relevant to this Contract for five (5) years after final payment or until after the resolution of any audit questions which could be more than five (5) years, whichever is longer. The County, Federal or State auditors and any other persons duly authorized by the Department shall have full access to, and the right to examine, copy and make use of, any and all said materials.

If the Contractor's books, records and other documents relevant to this Contract are not sufficient to support and document that requested services were provided, the Contractor shall reimburse Maricopa County for the services not so adequately supported and documented.

4.11 AUDIT DISALLOWANCES:

If at any time County determines that a cost for which payment has been made is a disallowed cost, such as overpayment, County shall notify the Contractor in writing of the disallowance. County shall also state the means of correction, which may be but shall not be limited to adjustment of any future claim submitted by the Contractor by the amount of the disallowance, or to require repayment of the disallowed amount by the Contractor.

4.12 VALIDITY:

The invalidity, in whole or in part, of any provision of the Contract shall not void or affect the validity of any other provision of this Contract.

4.13 RIGHTS IN DATA:

The County shall have the use of data and reports resulting from this Contract without additional cost or other restriction except as provided by law. Each party shall supply to the other party, upon request, any available information that is relevant to this Contract and to the performance hereunder.

4.14 INTEGRATION

This Contract represents the entire and integrated agreement between the parties and supersedes all prior negotiations, proposals, bids, communications, understandings, representations, or agreements, whether oral or written, express or implied.

4.15 GOVERNING LAW:

The laws of the State of Arizona will govern this contract.

IN WITNESS WHEREOF, this Contract is executed on the date set forth above.

CONTRACTOR

AUTHORIZED SIGNATURE

PRINTED NAME AND TITLE

ADDRESS

DATE

MARICOPA COUNTY

BY: _____
CHAIRMAN, BOARD OF SUPERVISORS

DATE

ATTESTED:

CLERK OF THE BOARD

DATE

APPROVED AS TO FORM:

MARICOPA COUNTY ATTORNEY

DATE

EXHIBIT A
SERIAL 01178-RFP
PRICING SHEET S063202

BIDDER NAME:	United Behavioral Health
F.I.D./VENDOR #:	W000000468 X
BIDDER ADDRESS:	425 Market Street, 27th Floor San Francisco, CA 94105-2426
P.O. ADDRESS:	
BIDDER PHONE #:	(415) 547-5000
BIDDER FAX #:	(415) 547-6100 (San Francisco Account Management Department)
COMPANY WEB SITE:	www.ubhnet.com
COMPANY CONTACT (REP):	Ms. Kay Hall, M.S. CLU Regional Vice President of Sales (503) 274-4631
E-MAIL ADDRESS (REP):	kay_p_hall@uhc.com

WILLING TO ACCEPT FUTURE SOLICITATIONS VIA EMAIL:
☒ YES ☐ NO

PAYMENT TERMS: BIDDER IS REQUIRED TO PICK ONE OF THE FOLLOWING.
 TERMS WILL BE CONSIDERED IN DETERMINING LOW BID.
 FAILURE TO CHOOSE A TERM WILL RESULT IN A DEFAULT TO NET 30.
 BIDDER MUST INITIAL THE SELECTION BELOW.

NET 10	_____
NET 15	_____
NET 20	_____
NET 30	_____
NET 45	_____ X _____
NET 60	_____
NET 90	_____
2% 10 DAYS NET 30	_____
1% 10 DAYS NET 30	_____
2% 30 DAYS NET 31	_____
1% 30 DAYS NET 31	_____
5% 30 DAYS NET 31	_____

1.0 Behavioral Health		Mo. Rate 2003	Mo Rate 2004	Mo Rate 2005	Mo Rate 1-1-05 to 6-30-07
1.1 Fully Insured	Employee Only	\$5.68 \$ 6.25	\$ 6.88	\$ 7.49	\$ 8.49
	Employee + Children	\$9.38 \$10.32	\$11.35	\$14.97	\$16.98
	Employee + Spouse	\$11.37 \$12.51	\$13.76	\$12.35	\$14.00
	Employee + Family	\$15.06 \$16.57	\$18.23	\$19.83	\$22.49
	Pre-65 Retiree	\$5.68 \$ 6.25	\$ 6.88	\$ 7.49	\$ 8.49
	Pre-65 Retiree + Family	\$11.37 \$12.51	\$13.76	\$14.97	\$16.98
	Post-65 Retiree	\$2.84 \$ 3.12	\$ 3.43	\$ 3.73	\$ 4.23
	Post-65 Retiree + Family	\$7.53 \$ 8.28	\$ 9.11	\$ 9.91	\$11.24
1.2 Psychworks Program			\$ 0.18 pepm		
1.2. DISABILITY SOLUTIONS			\$0.20 pepm		
1.3. HIGH RISK MEDICAL INTERVENTION			\$0.24 pepm		
1.4. WEIGHT MANAGEMENT ON-LINE			\$0.06 pepm		
1.5 DISABILITY SOLUTIONS (NON MEDICAL)					
(2 sessions, covered coordination and follow up).			\$600.00 per case		

How long are the above pricing factors guaranteed?
 UBH guarantees the quoted rates for 180 days going forward.

EXHIBIT B

MARICOPA COUNTY

Behavioral Health Benefits

January 1, 2003



United Behavioral Health

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Certification

CERTIFICATE OF INSURANCE

**for Employees of
Maricopa County
(called the Employer)**

insured by

**UNITED HEALTHCARE INSURANCE COMPANY
Hartford, Connecticut
(called the Company)**

United HealthCare Insurance Company has issued Group Policy No. GA-(unassigned). It covers certain Employees of the Employer.

The policy provides Behavioral Health Benefits.

This Certificate of Insurance describes the benefits and provisions of the policy. Additional benefits and provisions may apply based on the requirements of:

- The state where the policy is issued.
- The state where the Employee lives.

These state benefits and provisions are described in separate Amendments. See the Employer for details.

This is a Covered Person's Certificate of Insurance only while that person is insured under the policy. Dependents benefits apply only if the Employee is insured under the Employer's Plan for Dependent Benefits.

This Certificate describes the Plan in effect as of January 1, 2003

This Certificate replaces any and all Certificates previously issued for Employees under the plan.

UNITED HEALTHCARE INSURANCE COMPANY

Ronald B. Colby
Chairman & CEO

The Behavioral Health Benefits described in this Plan are administered by United Behavioral Health.

1-800-888-2998

C-CE1AZ, C-SB1, C-EL1, C-RE1, C-MH2, C-CI1, C-CB1, C-RP1, C-EM1, C-TE1, C-GL1

Schedule of Benefits

Effective Date of this Plan **January 1, 2003**

Behavioral Health Benefits

Covered Person's Responsibility		
	Network	Non-Network
Inpatient Copayment	\$25 Per Day	Not Covered
Inpatient Non-notification Deductible if precertification is not obtained	\$400	Not Covered
Residential Treatment Copayment	\$12.50 Per Day	Not Covered
Intensive Outpatient Copayment	\$100 Per Program	Not Covered
Outpatient Individual Copayment	\$10 Per Visit	Benefit covers \$25 per visit
Outpatient Group Therapy Copayment	\$5 Per Visit	Benefit covers \$25 per visit
Maximum Benefits	Network	Non-Network
Mental Health/Substance AbuseCalendar Year Maximum Outpatient	30 individual visits Network and Non-Network combined 60 group therapy visits Network and Non- Network Combined	
Mental Health/Substance AbuseCalendar Year Maximum Inpatient/Residential	30 inpatient days 60 residential days	Not Covered
Mental Health/Substance Abuse Lifetime Maximum	Unlimited	\$5,000,000

All benefits, except for Non-Network Outpatient Mental Health and Substance Abuse services are paid in accordance with the Reasonable Charge. Refer to the Glossary for the definition of Reasonable Charge.

Non-Network services are subject to Utilization Review at the time a claim is submitted for payment in order to

Maricopa County Certificate of Insurance

July 12, 2002

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determine if the services meet the Clinical Necessity criteria for Behavioral Health Services.

Eligibility

Eligible Employees

All Employees and retirees of the Employer enrolled in a Maricopa County sponsored medical plan. Employees must have their permanent residence in the United States

Eligible Dependents

Dependents are:

- A wife or husband of an eligible Employee.
- Any unmarried child from birth through age 19 of an eligible Employee.
- An unmarried child under age 25 of an eligible Employee, if the child is a registered student in regular full-time attendance at school. The child must be mainly dependent on the Employee for care and support. •
A child under the age of 25 of an eligible Employee, if the child is a registered student in regular full-time or part-time attendance at school or is mainly dependent on the Employee for care and support or the child is living in the household of an eligible Employee. A child under age 25 on a church mission.

Child includes the following:

- A stepchild who resides in the eligible Employee's home.
- A legally adopted child. (A child is considered legally adopted on the earlier of the date of placement or the date the legal adoption proceedings have been started.)
- Any other child related to an eligible Employee, mainly dependent on the eligible Employee for care and support and residing in the eligible Employee's home.
- Any unmarried child who is legally dependent on the Employee or the Employees Spouse.

Dependents must have their permanent residence in the United States

Cost of Coverage

The coverage under this Plan is contributory. This means that Employees must make contributions toward the cost of coverage.

Enrollment Requirements

Enrollment Date

The date the person is enrolled under this Plan.

Employee Coverage

An Employee enrolls for Employee coverage by:

Maricopa County Certificate of Insurance
July 12, 2002

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- completing an enrollment form, and
- giving the form to the Employer.

An Employee's enrollment is either timely or late.

An Employee is considered a timely enrollee if he or she enrolls during either the Initial Eligibility Period or a Special Enrollment Period.

An Employee is considered a late enrollee when he or she enrolls during the Annual Enrollment Period.

Dependent Coverage

No person can be covered both as an Employee and as a Dependent.

Initial Dependents are those family members who are eligible Dependents on the date the Employee first becomes eligible for Employee coverage.

Subsequent Dependents are any family members who become Eligible Dependents after the date the Employee first becomes eligible under this Plan. Subsequent Dependents may be added during a Special Enrollment Period.

A Dependent's enrollment is either timely or late.

A Dependent is considered a timely enrollee when he or she is enrolled for coverage during either the Initial Eligibility Period or a Special Enrollment Period.

A Dependent is considered a late enrollee when he or she enrolls during the Annual Enrollment Period.

Enrollment Periods

The Initial Eligibility Period is the 60-day period which begins on the date the person is first eligible under this Plan.

Employees and/or Dependents who are not enrolled during the Initial Eligibility Period or a Special Enrollment Period must wait until the next Annual Enrollment Period to enroll for coverage.

The Annual Enrollment Period is designated by the Employer each year. It is held before the start of each Plan Year. During this period, all eligible Employees and Dependents can enroll for coverage.

Special Enrollment Periods are available to certain persons who have lost other coverage and to certain dependents.

A Special Enrollment Period is available to a person who meets each of the following conditions:

- The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the Employee or Dependent.
- The Employee stated in writing, at the time coverage was previously offered, that the other coverage was the reason for declining enrollment under this Plan. The Employer must have requested the statement at that time. The Employer must have provided the Employee with notice of this requirement (and its consequences) at that time.
- The Employee's or Dependent's prior coverage was one of the following:
 - COBRA continuation which was exhausted.

- Non-COBRA coverage which was terminated either as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were terminated.
- The Employee requests enrollment under this Plan not later than 31 days after the date of the end of the COBRA continuation, termination of coverage, or termination of Employer contribution.

A Special Enrollment Period is available to Subsequent Dependents. The Dependent Special Enrollment Period is the 31-day period which begins with the date the person becomes a Dependent.

If a Subsequent Dependent is enrolled, the Employee must enroll at the same time if not already covered. In addition, any of the Employee's other Dependents may be enrolled at the same time, if not already covered, subject to the same enrollment requirements.

Late Enrollees

A late enrollee can enroll only during an Annual Enrollment Period.

Effective Date of Employee Coverage

Employee coverage is effective on the first day of the month coincident with or next following the latest of:

- The Effective Date shown in **Schedule of Benefits**.
-
- The first day of the pay period following 14 days after the date an enrollment form is received within 60 days of hire, unless, the Employee specifies a later date provided that date is the first day of a pay period.

Effective Date of Dependent Coverage

Coverage for an Initial Dependent(s) is effective on the later of the following dates:

- The date the Employee becomes covered.
- The date the Employee enrolls the Dependents.

Coverage for a Subsequent Dependent is effective as follows:

- For a spouse, the date of marriage.
- For a newborn child, the date of birth.
- For an adopted child, the date of adoption or placement for adoption.
- For any other child, the date the child becomes a Dependent.

Qualified Medical Child Support Order

If an Employee is required by a qualified medical child support order, as defined in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), to provide coverage for his/her children, these children can be enrolled as timely enrollees as required by OBRA 93.

If the Employee is not already enrolled, the Employee may also enroll as a timely enrollee at the same time.

Plan Benefits are payable for a newborn child for 31 days after the child's birth, even if the Employee has not enrolled the child.

Maricopa County Certificate of Insurance

July 12, 2002

*** Changes to this document are subject to the approval of the Arizona Department of Insurance**

Special Provision for Newborn Children

Plan Benefits are payable for a newborn child for 31 days after the child's birth, even if the Employee has not enrolled the child.

If additional contributions are required from the Employee for the coverage of that child, the Employee must enroll the child during the 31-day Special Enrollment Period in order for the child to be a timely enrollee.

Retired Employee Coverage

Retired Employees are eligible for the benefits as described below after they stop being an Active Employee.

As a Retired Employee, Plan Benefits are continued. The continued coverage will be the same coverage as for Active Employees, except as described below.

- The coverage for Retirees and Dependents is contributory. Retired Employees will have to pay the required contributions for the cost for their coverage.
- The continued benefits for Medicare Eligibles are modified as shown in **Medicare and Other Government Plans**.

Definitions

Retired Employee

Retired Employee means an Employee who meets all of the following:

- The Employee is retired by the Employer.
- The Employee receives retirement income either from the Employer or as a result of service with the Employer.
- The Employee was covered under this Plan or the Former Plan on the day before the date of retirement.

Totally Disabled or Total Disability

A Retired Employee's inability due to accidental injury or sickness to perform the normal activities of a person in good health and of like age and sex.

Behavioral Health Benefits

What This Plan Pays

Behavioral Health Benefits are payable for Covered Expenses incurred by a Covered Person for Behavioral Health Services received from either Network Providers (Inpatient and Outpatient Services) or Non-Network Providers(Outpatient Services only).

To receive the higher level of benefits, the Covered Person must call United Behavioral Health (UBH) before Inpatient Services are incurred. (See **Notification Requirements and Utilization Review**.)

Each Covered Person must satisfy certain Copayments and/or Deductibles before any payment is made for certain Behavioral Health Services. The Behavioral Health Benefit will then pay the percentage of Covered Expenses shown in **Schedule of Benefits**.

A Covered Expense is incurred on the date that the Behavioral Health Service is given.

Covered Expenses are the actual cost to the Covered Person of the Reasonable Charge for Behavioral Health Services given. The Company, at its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with the methodologies:

- In the most recent edition of the Current Procedural Terminology and/or DSM IV Code;
- As reported by generally recognized professionals or publications.

Behavioral Health Services are services and supplies which are:

- Clinically Necessary, as determined by the Company, for Mental Disorder Treatment.
- Given while the Covered Person is covered under this Plan.
- Given by one of the following providers:
 - Physician.
 - Psychologist.
 - Licensed Counselor.
 - Health Care Provider.
 - Hospital.
 - Treatment Center.

Behavioral Health Services include but are not limited to the following:

- Assessment.
- Diagnosis.
- Treatment Planning.
- Medication Management.
- Individual, family and group psychotherapy.
- Psychological testing.

Services and supplies will not automatically be considered Clinically Necessary because they were prescribed by a health care provider.

"Clinically Necessary" services or supplies are defined as services and supplies that meet all the following criteria:

Services or supplies are Clinically Necessary, as determined by the Company, if they meet all of the following:

- They are consistent with the symptoms and signs of diagnosis and treatment of the Covered Person's behavioral disorder, psychological injury or substance abuse.
- They are consistent in type and amount with regard to the standards of good clinical practice.
- They are not solely for the convenience or preference of the Covered Person, or his/her health care provider.
- They are the least restrictive and least intrusive appropriate supplies or level of service which can be safely provided to the Covered Person.

The Company may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations regarding whether particular services, supplies or accommodations provided or

to be provided to a Covered Person were/are Clinically Necessary.

Notification Requirements and Utilization Review

To receive the higher level of benefits under this Plan (called the Network level) and not incur the penalties shown below, the Covered Person must call United Behavioral Health (UBH) before **inpatient** Behavioral Health Services are given. **The toll-free number is 1-800-888-2998. UBH is ready to take the Covered Person's call 7 days a week, 24 hours a day.** This call starts the Utilization Review process. The Covered Person will be referred to a Network Provider who is experienced in addressing his/her specific issues.

Benefits under this Plan are reduced as follows if the Covered Person does not get a referral from UBH to a UBH Network Provider before **inpatient** Behavioral Health Services are given:

- Benefits are reduced by a \$400 Non-notification Deductible as shown in **Schedule of Benefits**.
- Benefits are subject to Utilization Review at the time a claim is submitted for payment in order to determine if the services incurred meet the Clinical Necessity criteria for Behavioral Health Services.

If the Covered Person is not satisfied with a Network Provider, he/she may call UBH and ask for a referral to another Network Provider. The Covered Person may do this more than once, but he/she will only be referred to one Network Provider at a time.

UBH performs a Utilization Review to determine the Clinical Necessity of Behavioral Health Services. The Covered Person and his/her health care provider decide which Behavioral Health Services are given, but this Plan only pays for Behavioral Health Services that are Clinically Necessary as determined by UBH.

Appeals

The Covered Person may appeal a Utilization Review or benefit reduction. See How to Appeal a Claim Decision for further information.

Emergency Care

Emergency Care does not require a referral from UBH to a UBH Network Provider.

When Emergency Care is required for Mental Disorder Treatment, the Covered Person (or his/her representative or his/her health care provider) must call UBH within one day after the Emergency Care is given. If it is not reasonably possible to make this call within one calendar day, the call must be made as soon as reasonably possible.

When the Emergency Care has ended, the Covered Person must get a referral from UBH before any additional services will be covered at the Network level. If the Covered Person does not get a referral as required, benefits for any additional services are payable at the Non-Network level.

Copayments and Deductibles

Before Behavioral Health Benefits are payable, each Covered Person must satisfy certain Copayments and/or Deductibles.

A Copayment is the amount of Covered Expenses the Covered Person must pay to a Network Provider at the time services are given. Copayments are not counted toward any Deductible. Behavioral Health Services which require a Copayment are not subject to a Deductible.

A Deductible is the amount of Covered Expenses the Covered Person must pay before Behavioral Health Benefits are payable. After the Deductible has been met, Covered Expenses are payable at the percentage shown in **Schedule of Benefits**.

The amount of each Copayment/Deductible is shown in **Schedule of Benefits**. A Covered Expense can only be used to satisfy one Copayment or Deductible.

Office Visit Copayment

The Office Visit Copayment applies to services given by a Network Provider. It applies to all services and supplies given in connection with each office visit.

Network Inpatient Copayment

The Network Inpatient Copayment applies to all services and supplies given in connection with each confinement in a Network Provider Facility.

Maximum Benefit

The Maximum Benefit payable for each Covered Person is shown in **Schedule of Benefits**. This maximum applies to each Covered Person's lifetime.

The Maximum Benefit includes any amount paid under the Employer's group health plan in effect on the day before the effective date of this Plan.

Extended Benefits

Extended Benefits are payable for a Totally Disabled Covered Person for up to 3 months. Extended Benefits are only payable for Behavioral Health Services given during the 3-month period after the person's coverage ends.

The person must be continuously Totally Disabled due to the same cause from the date coverage ends until the date Behavioral Health Services are given.

Extended Benefits are only payable for Behavioral Health Services given for the injury or sickness causing Total Disability.

Not Covered

This Plan does not cover any expenses incurred for services, supplies, medical care or treatment relating to, arising out of, or given in connection with, the following:

- Services or supplies which are not Clinically Necessary, including any confinement or treatment given in connection with a service or supply which is not Clinically Necessary.
- Services or supplies received before the Covered Person or his/her Dependent becomes covered under this Plan.
- Expenses incurred by a Dependent if the Dependent is covered as an Employee for the same services under this Plan.
- Treatment given in connection with any of the following diagnoses: mental retardation (except initial diagnosis), autism, pervasive developmental disorders, chronic organic brain syndrome, learning disability, or transsexualism.
- Completion of claim forms or missed appointments.
- Custodial Care that has not been approved by UBH. This is care made up of services and supplies that meets one of the following conditions:
 - Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather

than to provide medical treatment.

- Care that can safely and adequately be provided by persons who do not have the technical skills of a covered health care professional.

Care that meets one of the conditions above is custodial care regardless of any of the following:

- Who recommends, provides or directs the care.
 - Where the care is provided.
 - Whether or not the patient or another caregiver can be or is being trained to care for himself or herself.
- Education, training and bed and board while confined in an institution which is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home.
 - Herbal medicine, holistic or homeopathic care, including drugs.
 - Services, supplies, medical care or treatment given by one of the following members of the Employee's immediate family:
 - The Employee's spouse.
 - The child, brother, sister, parent or grandparent of either the Employee or the Employee's spouse.
 - Services or supplies, treatments or drugs which are considered investigational because they do not meet generally accepted standards of medical practice in the United States. This includes any related confinements, treatment, service or supplies.
 - Services and supplies for which the Covered Person is not legally required to pay.
 - Membership costs for health clubs, weight loss clinics and similar programs.
 - Nutritional counseling.
 - Occupational injury or sickness - an occupational injury or sickness is an injury or sickness which is covered under a workers' compensation act or similar law. For persons for whom coverage under a workers' compensation act or similar law is optional because they could elect it or could have it elected for them, occupational injury or sickness includes any injury or sickness that would have been covered under the workers' compensation act or similar law had that coverage been elected.
 - Examinations or treatment ordered by a court in connection with legal proceedings unless such examinations or treatment otherwise qualify as Behavioral Health Services.
 - Examinations provided for employment, licensing, insurance, school, camp, sports, adoption or other non-Clinically Necessary purposes, and related expenses for reports, including report presentation and preparation.
 - Services given by a pastoral counselor.
 - Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners humidifiers, saunas, hot tubs.
 - Private duty nursing services while confined in a facility.
 - Sensitivity training, educational training therapy or treatment for an education requirement.
 - Sex-change surgery.
 - Stand-by services required by a Physician.
 - Telephone consultations.
 - Tobacco dependency.
 - Weight reduction or control (unless there is a diagnosis of morbid obesity), special foods, food supplements, liquid diets, diet plans or any related products.

- Services given by volunteers or persons who do not normally charge for their services.

Network Provider Charges Not Covered

A Network Provider has contracted to participate in the Network and provide services at a negotiated rate. Under this contract a Network Provider may not charge for certain expenses, except as stated below. A Network Provider cannot charge for:

- Services or supplies which are not Clinically Necessary;
- Fees in excess of the negotiated rate.

A Covered Person may agree with the Network Provider to pay any charges for services and supplies which are not Clinically Necessary. In this case, the Network Provider may make charges to the Covered Person. The Covered Person will be asked to sign a patient financial responsibility form agreeing to pay for the services that are found to not be Clinically Necessary. However, these charges are not Covered Expenses under this Plan and are not payable by the Company.

Claims Information

How to File a Claim

A claim form does not need to be filed when a Network Provider is used.

The following steps should be completed when submitting bills for payment:

- Get a claim form from the Employer, the Plan Administrator or United Behavioral Health.
- Complete the Employee portion of the form.
- Have the provider complete the provider portion of the form.
- Send the form and bills to the address shown on the form.

Make sure the bills and the form include the following information:

- The Employee's name and social security number.
- The Employer's name and contract number (unassigned).
- The patient's name.
- The diagnosis.
- The date the services or supplies were incurred.
- The specific services or supplies provided.

If the covered Employee asks for a claim form but does not receive it within 15 days, the covered Employee can file a claim without it by sending the bills with a letter, including all of the information listed above.

When Claims Must be Filed

The covered Employee must give the Company written proof of loss within 15 months after the date the expenses are incurred.

The Company will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested.

No benefits are payable for claims submitted after the 15-month period, unless it can be shown that:

- It was not reasonably possible to submit the claim during the 15-month period.
- Written proof of loss was given to the Company as soon as was reasonably possible.

How and When Claims Are Paid

All payments will be paid to the covered Employee as soon as United Behavioral Health receives satisfactory proof of loss, except in the following cases:

- If the covered Employee has financial responsibility under a court order for a Dependent's medical care, United Behavioral Health will make payments directly to the provider of care.
- If United Behavioral Health pays benefits directly to Network Providers.
- If the covered Employee requests in writing that payments be made directly to a provider. A covered Employee does this when completing the claim form.

These payments will satisfy the Company's obligation to the extent of the payment.

United Behavioral Health will send an Explanation of Benefits (EOB) to the covered Employee. The EOB will explain how United Behavioral Health considered each of the charges submitted for payment. If any claims are denied or denied in part, the covered Employee will receive a written explanation.

Any benefits continued for Dependents after a covered Employee's death will be paid to one of the following:

- The surviving spouse.
- A Dependent child who is not a minor, if there is no surviving spouse.
- A provider of care who makes charges to the covered Employee's Dependents for Behavioral Health Services.
- The legal guardian of the covered Employee's Dependent.

Legal Actions

The covered Employee may not sue on a claim before 60 days after proof of loss has been given to the Company. The covered Employee may not sue after three years from the time proof of loss is required, unless the law in the area where the covered Employee lives allows for a longer period of time.

Incontestability of Coverage

This Plan cannot be declared invalid after it has been in force for two years. It can be declared invalid due to nonpayment of premium.

No statement used by any person to get coverage can be used to declare coverage invalid if the person has been covered under this Plan for two years. In order to use a statement to deny coverage before the end of two years, it must have been signed by the person. A copy of the signed statement must be given to the person.

How to Appeal a Claim

If the Covered Person is not satisfied with a decision UBH has made regarding a request for Behavioral Health Benefits or payment of a claim for Behavioral Health Services, the Covered Person may pursue the levels of review available through UBH's appeals process. If the Covered Person has any questions regarding the Appeals Process, he or she should contact UBH at 1-800-888-2998. If the Covered Person participates in the Appeals Process, he or she waives any privilege of confidentiality of medical records regarding any person who examined or will examine the Covered Persons records in connection with the review process for the behavioral health condition under review.

The following levels of review are available to the Covered Person through the Appeals Process:

Expedited Review Process

This process is only available for the review of Behavioral Health Services that the Covered Person has not yet received. This process is not available for review of non-certified claims.

Expedited Clinical Review

In cases of non-certified services where a Physician or other Health Care Provider certifies that a delay will result in a significant negative impact to the Covered Person's behavioral health condition, the Covered Person or the Covered Person's representative may request an expedited medical review. UBH will resolve the request within one business day of the receipt of the request and all supporting documentation.

Expedited Appeal

If the Covered Person is not satisfied with the response at the expedited clinical review level, he or she may request an expedited appeal. The Covered Person must immediately submit a request to UBH. UBH will make a determination regarding the request within three business days of the receipt of the expedited appeal request.

Expedited External Independent Review

At any of the previous levels, UBH may escalate the Covered Person's request to the external independent review level. If the Covered Person is not satisfied with the outcome of a determination after an expedited appeal, he or she may request an expedited external, independent review. An external independent reviewer will make a determination within 15 business days of the receipt of the request for an expedited external independent review. The Covered Person's request must be submitted within five business days of receipt of the expedited appeal determination. UBH will acknowledge the request within one business day of receipt of the request for an expedited external independent review.

Standard Appeals Process

Informal Reconsideration

In cases of non-certified services where an expedited clinical review is not requested or necessary, the Covered Person or the Covered Person's representative may request, within two years of the non-certification, an informal reconsideration of the non-certification. UBH will acknowledge this request within five business days, and will make a determination regarding the request within 30 calendar days of receipt of the request for an informal reconsideration.

Formal Appeal

In the case of a non-certified claim, non-certified service, or if the Covered Person is not satisfied with the response at the informal reconsideration level, he or she may request a formal appeal. The Covered Person must submit a written request to UBH within 60 calendar days from the date of the response to an informal reconsideration, non-certified service or non-certified claim. UBH will acknowledge the request for a formal appeal within five business days of receipt of the request. In the case of a non-certified service, UBH will make a determination regarding the request within 30 calendar days, or in the case of a non-certified claim, within 60 calendar days of receipt of the request for a formal appeal.

External Independent Review

At any of the previous levels, UBH may escalate the Covered Person's request to the external independent review level. If the Covered Person is not satisfied with the outcome of a determination after a formal appeal, he or she may request an external independent review. An external independent reviewer will make a determination within 15 business days of the receipt of the request for an external independent review. External independent review requests from the Covered Person must be submitted in writing within 30 calendar days of receipt of the formal appeal determination. UBH will acknowledge the request within five business days of receipt of the request for an external independent review.

Contact Person for Processing the Review

If you have any questions regarding the appeals process, or need a copy of the Your Right to Appeal Packet, contact the UBH Appeals Unit at 1-800-888-2998, PO BOX 32040 Oakland, CA 94604 . Fax: 415-547-6259

Coordination of Benefits

Coordination of benefits applies when a covered Employee or a covered Dependent have health coverage under this Plan and one or more Other Plans.

One of the plans involved will pay the benefits first: that plan is Primary. Other Plans will pay benefits next: those plans are Secondary. The rules shown in this provision determine which plan is Primary and which plan is Secondary.

Whenever there is more than one plan, the total amount of benefits paid in a Calendar Year under all plans cannot be more than the Allowable Expenses charged for that Calendar Year.

Definitions

"Other Plans" are any of the following types of plans which provide health benefits or services for medical care or treatment:

- Group policies or plans, whether insured or self-insured. This does not include school accident-type coverage.
- Group coverage through HMOs and other prepayment, group practice and individual practice plans.
- Group-type plans obtained and maintained only because of membership in or connection with a particular organization or group.
- Government or tax supported programs. This does not include Medicare or Medicaid.

"Primary Plan": A plan that is Primary will pay benefits first. Benefits under that plan will not be reduced due to benefits payable under Other Plans.

"Secondary Plan": Benefits under a plan that is Secondary may be reduced due to benefits payable under Other Plans that are Primary.

"Allowable Expenses" means the necessary, reasonable and customary expense for health care when the expense is covered in whole or in part under at least one of the plans.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as defined in the plan.

When a plan provides benefits in the form of services, instead of a cash payment, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

How Coordination Works

When this Plan is Primary, it pays its benefits as if the Secondary Plan or Plans did not exist.

When this Plan is a Secondary Plan, its benefits are reduced so that the total benefits paid or provided by all plans during a Calendar Year are not more than total Allowable Expenses. The amount by which this Plan's benefits have been reduced shall be used by this Plan to pay Allowable Expenses not otherwise paid, which were incurred during the Calendar Year by the person for whom the claim is made. As each claim is submitted, this Plan determines its obligation to pay for Allowable Expenses based on all claims which were submitted up to that point in time during the Calendar Year.

The benefits of this Plan will only be reduced when the sum of the benefits that would be payable for the Allowable Expenses under the Other Plans, in the absence of provisions with a purpose like that of this **Coordination of Benefits** provision, whether or not claim is made, exceeds those Allowable Expenses in a Calendar Year.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Which Plan Pays First

When two or more plans provide benefits for the same Covered Person, the benefit payment will follow the following rules in this order:

- A plan with no coordination provision will pay its benefits before a plan that has a coordination provision.
- The benefits of the plan which covers the person other than as a dependent are determined before those of the plan which covers the person as a dependent.
- The benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent, if the person is also a Medicare beneficiary and both of the following are true:
 - Medicare is secondary to the plan covering the person as a dependent.
 - Medicare is primary to the plan covering the person as other than a dependent (example, a retired employee).
- When this Plan and another plan cover the same child as a dependent of parents who are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year. This is called the "Birthday Rule." The year of birth is ignored.

If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

If the other plan does not have a birthday rule, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

- If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - First, the plan of the parent with custody for the child.
 - Second, the plan of the spouse of the parent with the custody of the child.
 - Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health

care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This rule does not apply with respect to any claim for which any benefits are actually paid or provided before the entity has that actual knowledge.

- If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules that apply to dependents of parents who are not separated or divorced.
- The benefits of a plan which covers a person as an employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. The same rule applies if a person is a dependent of a person covered as a retiree or an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee, member or subscriber for the longer period are determined before those of the plan which covered that person for the shorter period.

In order to coordinate benefit payments, the Company needs certain information. It may get needed facts from or give them to any other organization or person such as another insurance carrier or a health care provider with an appropriate authorization form. The Covered Person must sign an authorization form in order for the Company to obtain the necessary information to coordinate benefit payments. If the Covered Person fails to sign an authorization form, this may impair the ability of the Company to evaluate or process a claim and may be the basis for denying claims for benefits.

A Covered Person must give the Company the information it asks for about other plans. If the Covered Person cannot furnish all the information the Company needs, the Company has the right to get this information from any other source such as another insurance carrier or a health care provider. If any other organization or person needs information to apply its coordination provision, the Company has the right to give that organization or person such information with the appropriate release form.

Right to Exchange Information

In order to coordinate benefit payments, the Company needs certain information. It may get needed facts from or give them to any other organization or person. The Company need not tell, or get the consent of, any person to do this.

A Covered Person must give the Company the information it asks for about other plans. If the Covered Person cannot furnish all the information the Company needs, the Company has the right to get this information from any source. If any other organization or person needs information to apply its coordination provision, the Company has the right to give that organization or person such information. Information can be given or obtained without the consent of any person to do this.

Facility of Payment

It is possible for benefits to be paid first under the wrong plan. The Company may pay the plan or organization or person for the amount of benefits that the Company determines it should have paid. That amount will be treated as if it was paid under this Plan. The Company will not have to pay that amount again.

Right of Recovery

The Company may pay benefits that should be paid by another plan or organization or person. The Company may recover the amount paid from the other plan or organization or person.

The Company may pay benefits that are in excess of what it should have paid. The Company has the right to recover the excess payment.

Effect of Medicare and Government Plans

Medicare

When a Covered Person becomes eligible for Medicare, this Plan pays its benefits in accordance with the Medicare Secondary Payer requirements of federal law. If the Employer is subject to the Medicare Secondary Payer requirements, this Plan will pay primary.

When This Plan Pays Primary to Medicare

This Plan pays primary to Medicare for Covered Persons who are Medicare eligible if:

- Eligibility for Medicare is due to age 65 and the employee has "current employment status" with the employer as defined by federal law and determined by the employer.
- Eligibility for Medicare is due to disability and the employee has "current employment status" with the employer as defined by federal law and determined by the employer.
- Eligibility for Medicare is due to end stage renal disease (ESRD) under the conditions and for the time periods specified by federal law.

When Medicare Pays Primary to this Plan

Medicare pays primary to this Plan for Covered Persons who are Medicare eligible if:

- The employee is a Retired Employee.
- Eligibility is due to disability and the Employee does NOT have "current employment status" with the employer as defined by federal law and determined by the employer.
- Eligibility for Medicare is due to end stage renal disease (ESRD), but only after the conditions and/or time periods specified in federal law cause Medicare to become primary.

See How this Plan Pays When Medicare is Primary.

Important! - Medicare Enrollment Requirements

When this Plan pays benefits first, without regard to Medicare, and the Covered Person wants Medicare to pay after this Plan, the Covered Person must enroll for Medicare Parts A and B. If the Covered Person does not enroll for Medicare when he or she is first eligible, the Covered Person must enroll during the special enrollment period which applies to that person when the person stops being eligible under this Plan.

When Medicare pays benefits first, benefits available under Medicare are deducted from the amounts payable under this Plan, whether or not the person has enrolled for Medicare. If Medicare pays first, the Covered Person should enroll for both Parts A and B of Medicare when that Covered Person is first eligible; otherwise, the expenses may not be covered by the Plan or Medicare.

How This Plan Pays When Medicare Is Primary

If Medicare pays benefits first, this Plan pays benefits as described below. This method of payment only applies to Medicare eligibles. It does not apply to any Covered Person unless that Covered Person becomes eligible under Medicare.

If the provider has agreed to limit charges for services and supplies to the charges allowed by Medicare (participating physicians), this Plan determines the amount of Covered Expenses based on the amount of charges allowed by Medicare.

If the provider has not agreed to limit charges for services and supplies to the charges allowed by Medicare (non-participating physicians), this Plan determines the amount of Covered Expenses based on the lesser of the following:

- The Reasonable Charges.
- The amount of the Limiting Charge as defined by Medicare.

This Plan determines the amount payable without regard to Medicare benefits. Then this Plan subtracts the amount payable under Medicare for the same expenses from Plan benefits. This Plan pays only the difference between Plan benefits and Medicare benefits.

The amount payable under Medicare which is subtracted from this Plan's benefits is determined as the amount that **would have been payable to a Medicare eligible covered under Medicare even if:**

- The person is not enrolled for Medicare Parts A and B. Benefits are determined as if the person were covered under Medicare Parts A and B.
- The expenses are paid under another employer's group health plan which is primary to Medicare. Benefits are determined as if benefits under that other employer's plan did not exist.
- The person is enrolled in a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) to receive Medicare benefits, and receives unauthorized services (out-of-plan services not covered by the HMO/CMP). Benefits are determined as if the services were authorized and covered by the HMO/CMP.

Government Plans (other than Medicare and Medicaid)

If the Covered Person is also covered under a Government Plan, this Plan does not cover any services or supplies to the extent that those services or supplies, or benefits for them, are available to that Covered Person under the Government Plan.

This provision does not apply to any Government Plan which by law requires this Plan to pay primary.

A Government Plan is any plan, program, or coverage — other than Medicare or Medicaid — which is established under the laws or regulations of any government, or in which any government participates other than as an employer.

Termination of Coverage

Employee Coverage

Employee coverage ends on the earliest of the following:

- The day this Plan ends.
- The last day of the pay period in which employment stops. • The last day of the pay period in which the person stops being an eligible Employee.
- The last day of a pay period for which contributions for the cost of coverage have been made, if the contributions for the next period are not made when due.

Dependent Coverage

Coverage for all of an Employee's Dependents ends on the earlier of the following:

- The day the Employee's coverage ends.
- The last day of a pay period for which contributions for the cost of Dependent coverage have been made, if the contributions for the next period are not made when due.

Coverage for an individual Dependent ends on the earlier of:

- The day the Dependent becomes covered as an Employee under this Plan.
- The last day of the pay period in which the Dependent stops being an eligible Dependent.

Continuation of Coverage for Incapacitated Children

A mentally or physically incapacitated child's coverage will not end due to age. It will continue as long as Dependents coverage under this Plan continues and the child continues to meet the following conditions:

- The child is incapacitated.
- The child is not capable of self-support.
- The child depends mainly on the Employee for support.

The Employee must give the Company proof that the child meets these conditions when requested. The Company will not ask for proof more than once a year.

Glossary

(These definitions apply when the following terms are used.)

Maricopa County Certificate of Insurance

July 12, 2002

*** Changes to this document are subject to the approval of the Arizona Department of Insurance**

Calendar Year

A period of one year beginning with a January 1.

Covered Person

The Employee and/or Retiree and the Employee and/or Retiree's wife or husband and/or Dependent children who are covered under this Plan.

Emergency Care

Immediate Mental Disorder Treatment when the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Employee

A person on the payroll of the Employer and regularly employed by the Employer on a full-time or part time basis of not less than 20 hours per week.

Health Care Provider

A licensed or certified provider other than a Physician whose services the Company must cover due to a state law requiring payment of services given within the scope of that provider's license or certification.

Hospital

An institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets one of the following three tests:

- It is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations.
- It is approved by Medicare as a hospital.
- It meets all of the following tests:
 - It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified Physicians.
 - It continuously provides on the premises 24-hour-a-day nursing service by or under the supervision of registered graduate nurses.
 - It is operated continuously with organized facilities for operative surgery on the premises.

Licensed Counselor

A person who specializes in Mental Disorder Treatment and is licensed as a Licensed Professional Counselor (LPC) or Licensed Clinical Social Worker (LCSW) by the appropriate authority.

Medicare

The Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act.

Mental Disorder Treatment

Mental Disorder Treatment is treatment for both of the following:

Maricopa County Certificate of Insurance
July 12, 2002

**** Changes to this document are subject to the approval of the Arizona Department of Insurance***

- Any sickness which is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence or addiction to alcohol or psychoactive drugs or medications, regardless of any underlying physical or organic cause, and
- Any sickness where the treatment is primarily the use of psychotherapy or other psychotherapeutic methods.

All inpatient services, including room and board, given by a mental health facility or area of a Hospital which provides mental health or substance abuse treatment for a sickness identified in the DSM, are considered Mental Disorder Treatment, except in the case of multiple diagnoses.

If there are multiple diagnoses, only the treatment for the sickness which is identified in the DSM is considered Mental Disorder Treatment.

Detoxification services given prior to and independent of a course of psychotherapy or substance abuse treatment is not considered Mental Disorder Treatment.

Prescription Drugs are not considered Mental Disorder Treatment.

Network Provider

A provider which participates in the network.

Non-Network Provider

A provider which does not participate in the network.

Physician

A legally qualified:

- Doctor of Medicine (M.D.).
- Doctor of Osteopathy (D.O.).

Plan

The group policy or policies issued by the Company which provide the benefits described in this Certificate of Insurance.

Post-service Claims

Post-service claims are those claims that are filed for payment of benefits after behavioral health care has been received.

Pre-service Claims

Pre-service claims are those claims that require notification or approval prior to receiving behavioral health care.

Psychologist

A person who specializes in clinical psychology and fulfills one of these requirements:

- A person licensed or certified as a psychologist.

- A Member or Fellow of the American Psychological Association, if there is no government licensure or certification required.

Reasonable Charge

As to charges for services rendered by or on behalf of a Network Physician, an amount not to exceed the amount determined by the Company in accordance with the applicable fee schedule.

As to all other charges, an amount measured and determined by the Company by comparing the actual charge for the service or supply with the prevailing charges made for it. The Company determines the prevailing charge. It takes into account all pertinent factors including:

- The complexity of the service.
- The range of services provided.
- The prevailing charge level in the geographic area where the provider is located and other geographic areas having similar medical cost experience.

Total Disability or Totally Disabled

- An Employee's inability to perform all of the substantial and material duties of his or her regular employment or occupation.
- A Dependent's inability to perform the normal activities of a person of like age and sex.

Treatment Center

A facility which provides a program of effective Mental Disorder Treatment and meets all of the following requirements:

- It is established and operated in accordance with any applicable state law.
- It provides a program of treatment approved by a Physician and the Company.
- It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services:
 - Room and board (if this Plan provides inpatient benefits at a Treatment Center).
 - Evaluation and diagnosis.
 - Counseling.
 - Referral and orientation to specialized community resources.

A Treatment Center which qualifies as a Hospital is covered as a Hospital and not as a Treatment Center.

Urgent Claims

Urgent claims are those Emergency Care claims that require notification or a benefit determination prior to receiving Mental Disorder Treatment.

Utilization Review

A review and determination as to the Clinical Necessity of services and supplies.

End of Certificate

Continuation of Health Coverage (COBRA)

This optional continuation only applies to Employees and their Dependents if it has been made available by the Employer. The Employer is required to offer this continuation in certain cases as a result of Public Law 99-272 (COBRA). This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. See the Employer to find out if and how this continuation applies to Employees and their Dependents.

In no event will the Company be obligated to provide continuation to a Covered Person if the Employer or its designated Plan Administrator fails to perform its responsibilities under federal law. These responsibilities include but are not limited to notifying the Covered Person in a timely manner of the right to elect continuation and notifying the Company in a timely manner of the Covered Person's election of continuation.

The Company is not the Employer's designated Plan Administrator and does not assume any responsibilities of a Plan Administrator pursuant to federal law.

If coverage under this Plan would have stopped due to a Qualifying Event, a Qualified Beneficiary may elect to continue coverage subject to the provisions below.

The Qualified Beneficiary may continue only the coverage in force immediately before the Qualifying Event.

The coverage being continued will be the same as the coverage provided to similarly situated individuals to whom a Qualifying Event has not occurred.

Coverage will continue until the earliest of the following dates:

- 18 months from the date the Qualified Beneficiary's health coverage would have stopped due to a Qualifying Event based on employment stopping or work hours being reduced.
- If a Qualified Beneficiary is determined to be disabled under the Social Security Act at any time during the first 60 days of continued coverage due to the employee's employment stopping or work hours being reduced, that Qualified Beneficiary may elect an additional 11 months of coverage under this Plan, subject to the following conditions:
 - The Qualified Beneficiary must provide the Employer with the Social Security Administration's determination of disability within 60 days of the time the determination is made and within the initial 18-month continuation period.
 - The Qualified Beneficiary must agree to pay any increase in the required payment necessary to continue the coverage for the additional 11 months.
 - If the Qualified Beneficiary entitled to the additional 11 months of coverage has nondisabled family members who are entitled to continuation coverage, those nondisabled family members are also entitled to the additional 11 months of continuation coverage.
- 36 months from the date the health coverage would have stopped due to the Qualifying Event other than those described above.

- For the spouse or dependent of an Employee who was entitled to Medicare prior to a qualifying event that is either the termination of employment or work hours being reduced, 18 months from the date of the qualifying event or if later, 36 months from the date of the Employee's Medicare entitlement.
- The date this Plan stops being in force.
- The date the Qualified Beneficiary fails to make the required payment for the coverage.
- The date the Qualified Beneficiary, after electing this continuation, becomes covered under Medicare or any other group health plan. (This does not apply if the other group health plan excludes or limits coverage for a Qualified Beneficiary's preexisting condition.)

If within the original 18 month continuation period, another Qualifying Event occurs, coverage can be continued for an additional period, for a total of 36 months from the date of the first Qualifying Event.

Coverage will stop for the same reasons as coverage would have stopped for the first Qualifying Event.

Election Period

A Qualified Beneficiary has at least 60 days to elect to continue coverage. The election period ends on the later of:

- 60 days after the date coverage would have stopped due to the Qualifying Event.
- 60 days after the date the person receives notice of the right to continue coverage.

Unless otherwise specified, an Employee or spouse's election to continue coverage will be considered an election on behalf of all other Qualified Beneficiaries who would also lose coverage because of the same Qualifying Event.

Required Payments

A Qualified Beneficiary has 45 days from the date of election to make the first required payment for the coverage. The first payment will include any required payment for the continued coverage before the date of the election.

Notification Requirements

A Qualified Beneficiary must notify the Employer within 60 days when any of the following Qualifying Events happen:

- The Qualified Beneficiary's marriage is dissolved.
- The Qualified Beneficiary becomes legally separated from his or her spouse.
- A child stops being an eligible Dependent.

The Employer will send the appropriate Election Form to the Qualified Beneficiary within 14 days after receiving this notice.

Conversion

At the end of this continuation period, a Qualified Beneficiary may be eligible for a conversion privilege if one is generally available under the plan.

Claims

File a claim by completing a medical claim form and attaching your bills to the form. "COBRA" should be written on the claim form and on each of the bills.

Special Terms that Apply to this Continuation Provision

Qualifying Event

A Qualifying Event is any of the following which results in loss of coverage for a Qualified Beneficiary:

- The Employee's employment ends (except in the case of gross misconduct).
- The Employee's work hours are reduced.
- The Employee becomes entitled to benefits under Medicare.
- The Employee's death.
- The Employee's marriage is dissolved.
- The Employee becomes legally separated from his/her spouse.
- The Employee's Dependent child stops being an eligible Dependent.

A bankruptcy is a Qualifying Event for certain Retired Employees and their Dependents under certain conditions. If there is a bankruptcy, Retired Employees should contact the Employer or the Company for more information.

Qualified Beneficiary

Any of the following persons who are covered under the plan on the day before a Qualifying Event:

- The Employee.
- An Employee's spouse.
- An Employee's former spouse (or legally separated spouse).
- A Dependent child, including a child born to or placed for adoption with the Employee during a period of continued coverage.

Continuation of Coverage During Family and Medical Leave (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) requires Employers to provide up to a total of 12 weeks of unpaid, job-protected leave during any 12-month period to eligible Employees for certain family and medical reasons. This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. See the Employer to find out details about how this continuation applies to you.

Reasons for Taking Leave

FMLA leave must be granted for any of the following reasons:

- Care of a child after birth.
- Care of a child after placement of that child with the Employee for adoption or foster care.
- Care of the Employee's spouse, child or parent (but not a parent-in-law) who has a serious health condition.
- A serious health condition that makes the Employee unable to work.

Employee Eligibility

To be eligible for FMLA benefits, all of the following must be true:

- The Employee must work for a covered Employer.
- The Employee must have worked for the Employer for at least 12 months.
- The Employee must have worked at least 1,250 hours over the previous 12 months.
- The Employee must work at a location where at least 50 employees are employed by the Employer within 75 miles.

Advance Notice and Medical Certification

The Employee must provide advance notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable."
- If the need for the leave is unforeseen, notice must be given as soon as practicable.
 - An Employer may require medical certification to support a request for leave because of a serious health condition, and may require a second or third opinion (at the Employer's expense) and a fitness for duty report to return to work.

Continuation of Coverage, Job Benefits and Protection

For the duration of a FMLA leave, the Employer must maintain the Employee's coverage. The Employee may continue the Plan benefits for himself or herself and his or her Dependents on the same terms as if the Employee had continued to work. The Employee must pay the same contributions toward the cost of the coverage that he or she made while working.

If the Employee fails to make the payments on a timely basis, the Employer, after giving you written notice, can end the coverage during the leave if payment is more than 30 days late.

- Upon return from a FMLA leave, most Employees must be restored to their original or equivalent positions with equivalent pay, benefits and other employment terms.
- The use of a FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an Employee's leave.

See the Employer for details about continuing group coverage other than the Plan benefits.

Intermittent Leave

Under some circumstances, an Employee may take a FMLA leave intermittently which means taking a leave in blocks of time, or by reducing his or her normal weekly or daily work schedule.

- Where a FMLA leave is for birth or placement for adoption or foster care, use of intermittent leave is subject to the Employer's approval.
- A FMLA leave may be taken intermittently whenever it is medically necessary to care for a seriously ill family member, or because the Employee is seriously ill and unable to work.

Substitution of Paid Leave

Subject to certain conditions, Employees or Employers may choose to use accrued **paid** leave (such as sick or vacation leave) to cover some or all of the FMLA leave. The Employer is responsible for designating if paid leave used by the Employee counts as a FMLA leave, based on information provided by the Employee. In no case can an Employee's paid leave be credited as a FMLA leave **after** the leave has been completed.

Spouses Who Work for the Same Employer

Spouses employed by the same Employer are jointly entitled to a **combined** total of 12 work weeks of family leave for the birth of a child or placement of a child for adoption or foster care, and to care for such child or to care for a parent who has a serious health condition.

Reenrollment after a FMLA Leave

If any or all of an Employee's coverages end while the Employee is on a FMLA leave, the Employee can reenroll for coverage when he or she returns to work from the FMLA leave.

The Employee and any Dependents will be considered timely enrollees if the Employee reenrolls within 31 days from the date he or she returns to work.



EXHIBIT B 1

August 21, 2002

Steve Dahle
Procurement Consultant
Materials Management Department
Materials Management Center
320 West Lincoln Street
Phoenix, AZ 85003-2494

Dear Steve,

This letter is to set forth certain understandings between United Behavioral Health (UBH) and Maricopa County (County) as it pertains to the administration of your mental health and substance abuse benefit. UBH agrees as follows:

1. The mental health and substance abuse (mhsa) benefit includes clinically necessary coverage for adults and adolescents in substance abuse residential treatment centers. The mhsa benefit also covers treatment for all DSM diagnoses, including V-codes, if the requested treatment meets UBH's criteria for clinically necessary care as defined in the Certificate of Insurance (Certificate).
2. The County shall provide UBH with 13 premium payments annually, equal to 1/13th of the annual contract amount. In addition, the County will provide UBH with a deposit equal to one month's total premium by January 10, 2003. UBH will extend the County a 45 day interest free grace period.
3. UBH will fund the costs of the initial mailing of the Certificates to member's homes. In regards to the delivery of the Certificate itself, UBH may mail them directly to member's homes or coordinate with Cigna for a joint mailing of the behavioral health and medical Certificates.
4. It is not likely that UBH/UHG will initiate any changes to the Policy, unless they are to comply with state or federal law. However, the County will always be given at least 30 days advance notice of Policy changes.

If you have any additional concerns, please let me know.

Best regards,

Jill Hargrave
Contracts Consultant

Cc: Pat Vancil
Mike Schaiberger
Russ Binicki
Sharon Fusco

EXHIBIT B 2
APPLICATION FOR GROUP INSURANCE
TO
UNITED HEALTHCARE INSURANCE COMPANY
Hartford, Connecticut

Employer — Maricopa County

Address — 320 West Lincoln Street
Phoenix, Arizona 85003-2494

The Employer applies for a Group Policy to cover its eligible Employees.

Employees of affiliated organizations under common control of or approved by the Employer may be covered. The Employer will have to request in writing that they be covered.

The Employees of other affiliated organizations will have coverage started or stopped when the Employer requests the Company in writing to do so. Coverage will start or stop according to the rules of the policy.

The term "Employer" will mean the Employer named above. It will also mean any affiliated organization the Employer has included under the policy.

The Employer will represent any affiliated organizations included under the policy. The Employer will take any required actions for them.

The Company identifies the policy as Policy Number GA-(unassigned). The policy includes any and all riders attached to it. The Employer has approved it and accepts its terms.

The policy will take effect on January 1, 2003 . Premium payments are required each month.

Any earlier application for the policy is replaced by this application.

Dated at Phoenix, Arizona

Maricopa County

_____ 20____

By _____

Witness: _____

Official Title _____

United HealthCare Insurance Company

450 COLUMBUS BOULEVARD
HARTFORD, CONNECTICUT

A STOCK COMPANY
(Hereinafter called the Company)

Employer — Maricopa County

and any affiliated organizations included under this policy.

Policy Number — GA-(unassigned)

Effective Date — January 1, 2003

First Policy Anniversary — January 1, 2004

Subsequent Policy Anniversaries — each January 1

State or other Jurisdiction of Issue — Arizona

The Company agrees to insure the Employer's eligible Employees and their eligible Dependents. The Company will do this while this policy stays in force. The Company agrees to pay the benefits of this policy to the Employees. The details of the benefits are shown in the Certificate(s) of Insurance and Notice(s) of Amendment which form a part of the policy.

Premiums

The Employer has applied for this policy and understands that it must pay the required premium to the Company to get the insurance and to keep it in force. The required premium may include retroactive adjustments in respect of previous periods including any additions, terminations or changes in coverage not shown in the Company's records at the time the premium for the previous period was calculated. All such billed premiums are due on The Premium Due Date which is the first day of each calendar month.

When This Policy Will Take Effect

This policy will take effect at the Employer's address on the Effective Date above, its date of issue. All periods of time that apply to this policy are deemed to begin and end at 12:01 A.M. at the Employer's address.

United HealthCare Insurance Company witnesses that this policy is executed on its date of issue at Hartford, Connecticut.

Policy Registrar

**Group Health Insurance: Non-Participating Term Insurance
Which can be Discontinued by the Company as Described in the Policy**

P-CV1, P-PI1, P-PP2, P-DP1

Maricopa County Policy Provisions
July 12, 2002

*** Changes to this document are subject to the approval of the Arizona Department of Insurance ***

PLAN OF INSURANCE COVERAGE

1. All of the benefits and provisions in the Certificate(s) of Insurance and Notice(s) of Amendment issued for the Employees shown in Paragraph 3 are included in and made a part of this policy.
2. When a reference to "you" or "your" is made in any Certificate of Insurance or Notice of Amendment, it will be a reference to an insured Employee.
3. The Certificate(s) of Insurance and Notice(s) of Amendment, each identified by a Document Number, the description of the Employees, and the Effective Date(s) of the Certificate(s) of Insurance and Notice(s) of Amendment are shown below. The Effective Date is the date that the benefits and provisions of the Certificate of Insurance or Notice of Amendment are to be included in the policy.

Employees	Document Number	Effective Date
All Eligible Employees	Certificate of Insurance - Document Number 03737582	January 1, 2003
All Eligible Employees - State of Issue Arizona	Notice of Amendment - Document Number 03737586	January 1, 2003

POLICY PROVISIONS

Premium Rates

The monthly premium for each insured Active or Retired Employee is as follows:

<u>For the period January 1, 2003 - January 1, 2004:</u>	<u>Rate:</u>
• Employee only	\$5.68
• Employee + Children	\$9.38
• Employee + Spouse	\$11.37
• Employee + Family	\$15.06
• Pre-65 Retiree	\$5.68
• Pre-65 Retiree + Family	\$11.37
• Post-65 Retiree	\$2.84
• Post-65 Retiree + Family	\$7.53

The Company's Right to Change the Rates

The Company can change the premium rates on:

- A Premium Due Date.
- The date of a change in Plan benefits or provisions.
- The effective date of any change in federal laws or state regulations which affect the Company's obligations under this policy.
- The date the number of covered Employees changes by 20% or more compared to the number of Employees covered under the policy on the later of (i) the Effective Date, or (ii) the effective date of the last change in the premium rates.

The Company also has the right to change the rates retroactive to the Effective Date if an Employee makes a material misrepresentation that affects the conditions under which the policy was issued.

However, the Company may not increase the rates before either of the following times, except for an increase due to a change in the number of Employees, a change in Plan, a change in federal laws or state regulations or Employee misrepresentation:

- The first Policy Anniversary.
- 12 months after a previous increase in premium rates.

The Employer will be notified at least 210 days in advance of any increase in premium rates. Preliminary rates are due 12 months prior to the anniversary date.

Maricopa County Policy Provisions
July 12, 2002

*** Changes to this document are subject to the approval of the Arizona Department of Insurance ***

Premiums: Where and How Payable

Premium is the money paid by the Employer to the Company for insurance coverage. Premiums are paid at the Home Office or to an authorized agent of the Company. Premiums are paid in advance each month on or before the Premium Due Date except that premiums for each conversion policy or certificate issued during a calendar quarter are paid to the Company quarterly in arrears.

Premium Computation and Adjustment

Premium Computation

Each monthly premium is calculated based on the number of enrollees, each enrollee's coverage classification the Company shows in its records at the time of the calculation and the premium rates then in effect.

The Employer shall notify the Company in writing within 30 days of the effective date of additions, terminations or other changes. The Employer shall notify the Company in writing each month of any changes in the coverage classification of any enrollee.

Premium Adjustment

The Company will make a retroactive adjustment of the premium for any additions, terminations or changes in coverage classification not shown in the Company's records at the time premium is calculated.

No retroactive credit will be made for:

- any change which occurs more than 90 days prior to the date the Employer notifies the Company of the change.
- any month in which an individual has received services or supplies under the terms of the policy.

The Employer may notify the Company in writing to end the policy during a time for which premium has been paid. The Company will make an adjustment of the premium to the Employer for the time between the date the policy ends and the end of the period for which premium has been paid.

Prospective Rating

Insurance under this policy is subject to prospective experience rating. This means that the Company will not at the end of any policy year retrospectively adjust the premium for such policy year because of claims experience. The claims experience of the class of business as a whole, of which the Employer is a part, and to the extent allowed by law, the claims experience of the Employer, will be used in part to determine future premium rates. To the extent allowed by law, the rates will also be based on some or all of the following characteristics of the Employer: age, sex, family status, industry or occupation, size of the Employer, location of the Employer, underwriting classification, duration of coverage since underwriting, health status of covered individuals, benefit plan design, and such other factors as the Company may determine from time to time.

Grace Period

This section applies only to premiums due after the Effective Date of the policy.

If premiums are not paid by a Premium Due Date, the policy will only stay in force for 45 days. The Employer must pay premiums for the time the policy stays in force. If written notice to end the policy is given by the Employer before the end of the 45 days, an adjustment of the premium will be made.

Employee's Individual Certificate

The Company will issue Certificates of Insurance and any attachments to the Employer for delivery to each covered Employee. The certificate and any attachments will show all the benefits and provisions of the health insurance plan.

Employer's Information Reports

The Company needs certain data. It is used to figure amounts of insurance and premiums. The Employer must give the data when it is requested by the Company.

Inspection of Records by the Company

The Company has the right to inspect records of the Employer that relate to the insurance or the premiums. The Company will have this right at all reasonable times.

Entire Contract

This policy is governed by the laws of the State or other Jurisdiction of Issue. The entire contract is made up of the following:

- The Maricopa County contract and all Exhibits and Clarifications attached to that document.
- This policy, including all Certificates and any attachments.
- The Employer's application.
- The Employees' applications, if there are any.

Unless there is fraud, all statements made by the Employer or Employees will be considered as statements of fact, not as guarantees.

A covered person's statement can not be used in defense to a claim under the policy unless a copy of the statement has been given to the person.

Clerical Error

Clerical error shall not deprive any person of coverage under the policy or create a right to benefits. Failure to report the termination of a person's coverage shall not continue such coverage beyond the date it is scheduled to end according to the terms of the policy. Upon discovery of a clerical error, any necessary appropriate adjustment in premium shall be made. However, the Company will not make an adjustment in premium or coverage for more than 90 days of coverage prior to the date the Employer notifies the Company of such clerical error.

Modifications

No one can change the policy, any of its conditions or the Premium Due Date without the written consent of the Company.

The Company can change the policy (including the benefits and provisions in the Certificates of Insurance) on a Policy Anniversary. The change must be effective on a uniform basis on all policies which provide the same type of group health product in the small and/or large group market. Employer agreement is not needed.

The policy can also be changed if the Company and the Employer agree. Employee agreement is not needed.

Any change has to agree with the laws of the State or other Jurisdiction of Issue.

Any change has to be signed by an Officer of the Company and attached to this policy before it is valid.

Benefits can not be reduced for an expense incurred before the date of the change.

No Replacement for Workers' Compensation

This policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

Discontinuance of Policy

The policy and all of the insurance ends on the earliest of the following:

- The date the premium is not paid when due. Unless the Employer gives advance written notice to the Company to end the policy, the Grace Period applies. During the Grace Period the policy stays in force for 45 days. The Employer must pay premium for the time the policy stays in force. The Grace Period applies even if the Employer replaces this policy with another plan of insurance but has not given notice to the Company.
- The first Premium Due Date after the Employer gives the Company written notice to end the policy. If the Employer does not give advance notice and the policy ends because the premium is not paid, the Grace Period applies. During the Grace Period the policy stays in force for 45 days. The Employer must pay premium for the time the policy stays in force. The Grace Period applies even if the Employer replaces this policy with another plan of insurance but has not given notice to the Company.
- The date specified by the Company, in advance written notice to the Employer, that the policy is discontinued for one of the following reasons:
 - The Employer has performed an act or practice that is fraud or made an intentional misrepresentation of material fact under the terms of the policy. The Company has the right to rescind this policy back to the effective date.
 - The Employer has failed to comply with the Company's employer contribution or group participation rules.
 - The number of Employees changes such that a large employer becomes a small employer. The small employer will be given the option to buy all other group health coverage currently offered by the Company in the small group market.

- The Company has stopped issuance of the type of group health coverage provided by this policy in a state for the small and/or large group market. The Company will give notice of the discontinuation to the Employer and Employees at least 90 days prior to the date of the discontinuation. The Employer will be given the option to buy all (or, if the Employer is a large employer, any) other health coverage currently offered by the Company.
- The Company has stopped issuance of all group health coverage in a state for the small and/or large group market. The Company will give notice of the discontinuation to the applicable state authority, the Employer and Employees at least 180 days prior to the date of discontinuation.
- There are no longer any Employees who reside or work in the network service area.
- The terms small employer, small group market, large employer and large group market will have the meaning given to them under applicable state or federal law.

END OF POLICY

EXHIBIT B 3

Legal & Financial Services Product Schedule

1. Definitions. For purposes of this Schedule, the capitalized terms shall have the following meaning:

Financial Counseling Referral: Access to information and/or referral to a financial counselor about a Participant financial matter.

Legal Counseling Referral Services: Access to information and/or referral to a legal professional about a Participant legal matter.

Family Mediation Services: Access to information and/or referral to a mediator to resolve family disputes in lieu of pursuing litigation.

2. Services. We shall provide the following:

2.1 Legal Counseling Referral

(a) **Services.** Legal Counseling Referral Services shall provide Participants with access to an attorney to consult about a personal legal matter. Within a reasonable time after obtaining information necessary to make a referral, eligibility will be determined for the Legal Counseling Referral Services and a teleconference between the Participant and an attorney will be arranged. If the attorney conducting the legal assistance telephone conference concludes that the needs of the Participant cannot be addressed through a telephone conference, the Participant will be referred to another attorney ("referral attorney"). The referral attorney will consult with the Participant at no charge for an initial half-hour consultation and 75% of the referral attorney's standard charges for subsequent services.

(b) **Limitation of Legal Counseling Referral Program.** Notwithstanding anything to the contrary in this Agreement or Schedule, Legal Counseling Referral Services are not available for Participants seeking second legal opinions, third party consultation, or assistance with employment law related questions.

2.2 Financial Counseling Referral

Services. Financial Counseling Referral Services shall provide Participants with telephone access to a financial counselor to discuss financial planning, debts, investments, or other financial matters.

2.3 Family Mediation

Services. Family Mediation Services shall provide Participants with access to a mediator to help resolve family disputes when it is determined that mediation would be a good alternative to litigation.

Liveandworkwell.com Services Product Schedule

1. Definitions. For purposes of this Schedule, the capitalized terms shall have the following meaning:

Liveandworkwell.com: Our member portal, which provides Participants with access to benefit and resource information, an online article library, numerous interactive tools and online discussions.

2. Services.

Liveandworkwell.com shall provide Participants with on-line access to information in one of the following major subject areas: family & friends, health & wellness, managing life changes, work & management and/or education & learning. Within the major subject areas, Participants may access the following:

- (a) Benefits and Referral information specific to your benefit plan.
- (b) Options for accessing our services
- (c) An article library, which provides informational articles on topics related to mental health issues.
- (d) On-line discussion groups that discuss designated wellness and self-help topics.
- (e) Resource information regarding mental health providers, colleges, bureau of consular affairs.
- (f) Interactive tools, including financial calculators, self-assessment tests, personal plans, and links to external resources.
- (g) Message boards for Participants to pose questions, get answers, and share ideas.

Communication Materials Product Schedule

Member Materials

We will provide you with one brochure or flyer (including a perforated wallet card) that describes the benefit for every eligible Employee and a mutually agreed upon number of posters. We will also provide you with a sample Managers Resource Guide.

All materials will include the toll-free telephone access number and the Group number, where appropriate.

Training Services Product Schedule

1. Definitions. For purposes of this Schedule, the capitalized terms shall have the following meaning:

Consultative Services. Services that incorporate a variety of approaches to effective employee management including needs analysis, human resource policy development, group facilitation, mediation of interpersonal and interdepartmental conflicts, and employee and management training and development programs.

Critical Incident. An unexpected, disruptive event, including, but not limited to, occurrences such as death or serious illness of a co-worker, acts of violence, situations requiring emergency medical assistance, extremely inappropriate or disruptive workplace behavior, threatening external acts such as robberies, fires and bombings, and natural disasters.

Critical Incident Stress Management ("CISM"). Services, which provide rapid, on-site intervention in response to any Critical Incident affecting the workplace. Specially trained debriefers conduct sessions that are educational in focus and help Participants understand how to process the normal emotional, mental, and physical reactions commonly experienced after a critical incident.

Training. Training includes, but is not limited to, behavioral health seminars designed to build personal awareness in Participants and encourage individual responsibility in facing one's own personal problems and management development designed to help managers build the skills to improve both interpersonal and organizational effectiveness in relating to Employees.

2. Services

2.1 Training and Consultative Services. We shall provide Training and Consultative Services upon thirty (30) days prior notification by you for scheduling purposes.

2.2 Critical Incident Stress Management ("CISM"). We shall provide Critical Incident Stress Management in response to any crisis or tragedy affecting the workplace. Debriefings are conducted within twenty-four (24) to forty-eight (48) hours after an incident occurs, based on the individual circumstances surrounding the incident.

3. Training, Consultative Services and CISM hours. We shall provide 50___ hours of Training, Consultative Services and CISM hours annually. Any additional Training, Consultative Services and/or CISM services are available on a fee-for-service basis. Services are billed at an hourly rate plus travel time. The fee-for-service rates are as follows:

Training and Consultation:	\$150.00/hour
CISM:	\$200.00/hour
Travel Time:	\$100.00/hour

Expenses for travel, hotels and car rental, etc. will be billed additionally.

HIPAA Addendum

1. Definitions. For purposes of this Schedule, the capitalized terms shall have the following meaning:

Designated Record Set. Has the meaning established for purposes of Title 45 part 164 of the United States Code of Federal Regulations, as amended from time to time, and includes currently a group of records maintained by or for a covered entity that is (i) the medical records and billing records about individuals maintained by or for a covered health care provider; (ii) the enrollment, payment, claims adjudication, and case or medical management records systems maintained by or for a health plan (as defined by and established for purposes of Title 45 part 160 of the United States Code of Federal Regulations, as amended from time to time); or (iii) used, in whole or in part, by or for the Covered Entity to make decisions about individuals (as defined by and established for purposes of Title 45 part 160 of the United States Code of Federal Regulations, as amended from time to time).

Health Care Operations. Has the meaning established for purposes of Title 45 part 164 of the United States Code of Federal Regulations, as amended from time to time.

Personal Health Information. Has the meaning established by the Gramm Leach Bliley Act set forth in Title 16 part 313 of the United States Code of Federal Regulations, as amended from time to time and which currently includes nonpublic personally identifiable information about a consumer in regards to health coverage including: (i) name, (ii) address, (iii) social security number(s), (iv) names of a spouse and dependents. It also includes information such as eligibility data and claims information.

Protected Health Information. Has the meaning established for purposes of Title 45 part 164 of the United States Code of Federal Regulations, as amended from time to time and currently includes any information:

- (a) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual;
- (b) that is transmitted or maintained by any electronic medium, including but not limited to, the Internet (wide-open), Extranet (using Internet Technology to link a business with information only accessible to collaborating parties), leased lines, dial up lines, private networks, and those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk media;
- (c) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and constitutes individually identifiable health information as defined by and established for purposes of Title 45 part 164 of the United States Code of Federal Regulations, as amended from time to time.

1.1 Protected Health Information. You understand and acknowledge that we may receive from or create or receive Protected Health Information as defined under the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and/or Personal Information, as defined under the Gramm Leach Bliley Act and implementing regulations ("GLB"), during the performance of its obligations under this Agreement. Except as otherwise specified herein, we may use or disclose Protected Health Information received from or created or received and Personal Information received from or created or received to perform functions, activities, or services as specified in this Agreement, provided that such use or disclosure would not violate the HIPAA privacy regulations, GLB or other federal or state privacy laws

1.2 Use and Disclosure for Legal Responsibilities. You agree that unless otherwise limited herein, we may:

- (a) use the Protected Health Information in our possession to fulfill any of our present or future legal responsibilities; and
- (b) disclose the Protected Health information in our possession to third parties to fulfill any of our present or future legal responsibilities provided, however, that the disclosures are required by law or we have received from the third party written assurances that:
 - (i) the information will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and
 - (ii) the third party will notify us of any instances of which it becomes aware in which the confidentiality of the information has been breached.

1.3 Use and Disclosure of Sensitive Information and/or Personal Information. With regard to our use and/or disclosure of Sensitive Information, we agree to:

- (a) not use or further disclose any Sensitive Information or Personal Information other than as permitted by this Agreement or required by law.

- (b) at all times maintain and use appropriate safeguards to prevent use or disclosure of any Sensitive Information other than as expressly set forth in this Agreement;
- (c) ensure that any subcontractor or agent to whom we provide any Sensitive Information to agrees in writing to the same conditions and restrictions that apply to us with regard to the Sensitive Information, including, without limitation, all of the requirements of this section.
- (d) provide access to Sensitive Information to individuals who have a right of access to information in a Designated Record Set in accordance with the HIPAA privacy regulations;
- (e) amend or correct Sensitive Information in a Designated Record Set in accordance with the HIPAA privacy regulations;
- (f) document disclosures of Sensitive Information and information related to such disclosure as would be required for us to respond to a request by an individual for an accounting of disclosures of Sensitive Information in accordance with the HIPAA privacy regulations;
- (g) respond to a request for an accounting of disclosures of Sensitive Information from an individual who has the right to an accounting of disclosure in accordance with the HIPAA privacy regulations;
- (h) make our internal practices, books and records relating to the use and disclosure of Sensitive Information available for review or audit by the Secretary of the U.S. Department of Health and Human Services (DHHS) for purposes of determining our compliance with the HIPAA privacy regulation;
- (i) require our subcontractors or vendors who act on our behalf as Business Associates (as the term is defined by the HIPAA privacy regulations) to, if feasible, return or destroy all Sensitive Information and/or Personal Information in their possession upon the termination the agreement with said Business Associate.

1.4 Electronic Transaction and Code Sets. We agree that we are required to comply with the HIPAA Standards for Electronic Transactions, 45 C.F.R. Parts 160 and 162 (HIPAA Electronic Transaction Law). The HIPAA Electronic Transaction Law currently requires us, as a Covered Entity and our Business Associates (as these terms are given the meaning under HIPAA established by Title 45 Part 160 of the United States Code of Federal Regulations, as amended from time to time, to conduct transactions covered by HIPAA Electronic Transaction Law as “standard transactions” using defined medical data code sets. The HIPAA Electronic Transaction Law sets forth the transactions covered by this law. The transactions covered by this law may be subject to change. The codes sets mandated in those transactions may also change. We agree to comply with the HIPAA Electronic Transaction Law as amended from time to time.

1.5 Interpretation. The terms and conditions of this Addendum, as applicable and required by HIPAA, shall be construed in light of any applicable interpretation of and/or guidance on HIPAA issued by DHHS. Any ambiguity in this section shall be resolved in favor of a meaning that permits compliance with applicable laws and regulations.

1.6 Effective Date. Each term and condition of this Addendum required by HIPAA and/or GLB shall be effective on the compliance date applicable to us, or this Agreement under HIPAA and/or GLB respectively.

PERFORMANCE STANDARDS SCHEDULE

Performance Standards with respect to this Agreement are set forth below. The Performance Standards are set for the following departments/categories: Implementation, Intake, Employee Satisfaction, Provider Satisfaction, Claims, Member Services, Account Management and Reports. The parties agree that failure by us to achieve the Performance Standards will result in the penalties set forth below; provided, however, that the maximum total penalty imposed upon us for failure to achieve one or more of the Performance Standards during the Initial Term or any Subsequent Term shall not exceed 2% of the fully insured Premium (hereinafter referred to as "Fee"), as set forth in Section 1.1 of Exhibit A, applicable to said Initial Term or Subsequent Term. Any failure by us to meet the Performance Standards described below does not constitute a breach of this Agreement by us.

I. PERFORMANCE STANDARDS

IMPLEMENTATION

STANDARD:	We shall complete those implementation tasks necessary to make contract operational by the effective date
DEFINITION:	Contracted services delivered and operational by the effective date of the contract. Standard not applicable if customer fails to provide information or perform tasks needed by us for implementation by the effective date.
MEASUREMENT:	Post Implementation Issues list
PENALTY:	\$10,000.00 Note: this penalty is a one time penalty, not subject to the 2% of the fully insured premium maximum

INTAKE

STANDARD:	Average time to answer clinical line shall be less than or equal to thirty (30) seconds
DEFINITION:	The time it takes for a Participant to reach a person live. It is measured by the automatic call distribution system. Wait time starts when a Participant gets in the queue to get a person live
MEASUREMENT:	Quarterly Reports
PENALTY:	0.075% of the Fee for each second over the target, not to exceed 0.15% of the Fee annually
STANDARD:	Average abandonment rate on the clinical line shall be less than or equal to 5%
DEFINITION:	Percentage of calls that hang up before speaking with a person live
MEASUREMENT:	Quarterly Reports

PENALTY: 0.075% of the Fee for each 1% over the target, not to exceed 0.15% of the Fee annually

PARTICIPANT SATISFACTION

STANDARD: 90% of Maricopa County Participants shall rate satisfied with our behavioral healthcare program.

DEFINITION: A Maricopa County approved survey shall be conducted of those Maricopa County Participants who have accessed services to determine satisfaction with the our services and participating provider network.

REPORTING: Annual Satisfaction Survey

PENALTY: 0.05% of the Fee for each 1% below the target, not to exceed 0.20% of the Fee annually

PROVIDER SATISFACTION

STANDARD: 90% of our participating providers geographically located in the State of Arizona shall rate satisfied with our behavioral healthcare program.

REPORTING: Annual Satisfaction Survey

PENALTY: 0.05% of the Fee for each 1% below the target, not to exceed 0.20% of the Fee annually

ACCOUNT MANAGEMENT

STANDARD: We shall receive a minimum rating of satisfactory by you

DEFINITION: Our ability to achieve a positive rating from you, as it pertains to the management of your account

REPORTING: The survey/scorecard will be responded to by your representatives annually.

PENALTY: 0.05% of the Fee for each line item not met, not to exceed 0.20% of the Fee annually

CLAIMS

STANDARD: Average claims coding accuracy shall be greater than or equal to 97%

DEFINITION: All line items audited, minus the items in error, divided by the total items audited. All errors are counted whether or not they result in an error in payment

REPORTING: Quarterly Reports

PENALTY: **0.075% of the Fee for each 1% below the target, not to exceed 0.15% of the Fee annually**

STANDARD: Average claims financial accuracy shall be greater than or equal to 99%

DEFINITION: Total number of dollars audited, minus the absolute value of total dollars paid in error, divided by the total dollars audited

REPORTING: Quarterly Reports

PENALTY: 0.075% of the Fee for each 1% below the target, not to exceed 0.15% of the Fee annually

STANDARD: 90% of Clean Claims shall be processed within 15 calendar/working days

DEFINITION: "Turn Around Time" is the measurement of the time from the date the claim is received to the date the claim is processed

"Received Date" means the date stamped on a claim by microfilm, identifying number, including julian date - date received in mailroom

"Processed Date" means the date the claim is fully processed and released for payment

"Clean Claims" means the claim does not have to be pended for further investigation (e.g. medical review, eligibility not matched, provider not loaded in the system).

REPORTING: Quarterly Reports

PENALTY: 0.05% of the Fee for each 1% below the target, not to exceed 0.15% of the Fee annually

MEMBER SERVICES

STANDARD: Average time to answer Member Services line shall be less than or equal to thirty (30) seconds

DEFINITION: The time it takes for a Participant to reach a person live. It is measured by the automatic call distribution system. Wait time starts when a Participant gets in the queue

MEASUREMENT: Quarterly Reports

PENALTY: 0.075% of the Fee for each second over the target, not to exceed 0.15% of the Fee annually

STANDARD: Average abandonment rate on the Member Services line shall be less than or equal to 5%

DEFINITION: Percentage of calls that hang up before speaking with a person live

MEASUREMENT: Quarterly Reports

PENALTY: 0.075% of the Fee for each 1% over the target, not to exceed 0.15% of the Fee annually

REPORTS

STANDARD: Standard Activity reports shall be delivered within forty-five (45) days following quarter's end.

DEFINITION: Production and delivery of accurate standard quarterly activity reports

MEASUREMENT: Date post-marked

PENALTY: **0.075% of the Fee for each day over the target, not to exceed 0.15% of the Fee annually**

STANDARD: Standard utilization reports shall be delivered within forty-five (45) days after the close of the ninety (90) day claim "run out" period

DEFINITION: Production and delivery of accurate standard annual utilization report

MEASUREMENT: Date post-marked

PENALTY: 0.075% of the Fee for each day over the target, not to exceed 0.15% of the Fee annually

II. TERM OF STANDARDS

These Standards shall become effective on the first day of January 2003, at 12:01 Pacific Standard Time and shall remain in effect for a period of twelve (12) consecutive months, ending on the last day of December 2003 (the "Term"). If the United HealthCare Insurance Policy is renewed at the end of the Term, these Standards shall also automatically renew at that time.

III. CALCULATION OF STANDARDS

Accuracy shall be measured by us, calculated on an average basis, and reported to you, as indicated for each performance standard. At our option, the accuracy of the results may also be measured by an independent firm of our choice.

Claims subject to review shall be randomly selected in a manner agreeable to both parties and shall be of a number sufficient to yield a 95% confidence level, with a 3% deviation in the coding/financial accuracy results.

All results shall be based on the audit sample.

IV. PAYMENT

Any refund payment owed at the end of the Term shall be issued on a credit basis against future Fee payments.

In the event of termination of the United HealthCare Insurance Policy, any monies owed with respect to these Standards shall be paid within one hundred and twenty (120) days of the termination date.

EXHIBIT B 4

(Attach this Notice to the Certificate of Insurance)

**NOTICE OF AMENDMENT
for**

Maricopa County

under Group Policy No. GA- (unassigned)

The Certificate of Insurance is amended on January 1, 2003 as follows to conform to the requirements of Arizona, which is the state of issue of the policy. This replaces any previous amendment issued to conform to the requirements of Arizona.

Benefits payable under this Amendment will not duplicate benefits for the same expenses that are payable under the Plan shown in the Certificate. If the benefits required by state law that are payable under this Amendment are greater than the benefits payable under this Plan shown in the Certificate, the benefits required by state law are payable. If this Plan's benefits are greater than the benefits required by state law, this Plan's benefits are payable. In no event will more than the greater of either of the following be paid:

- **This Plan's benefits, or**
- **The benefits required by state law.**

Benefits are payable only for services and supplies which are Clinically Necessary.

All other terms, provisions and conditions shown in the Certificate will continue to apply.

A-AZMH

Maricopa County AZ State Amendment
July 12, 2002

*** Changes to this document are subject to the approval of the Arizona Department of Insurance ***

Dependent Children

- Children who are eligible Dependents include:
 - The Employee's stepchild.
 - The Employee's legally adopted child (including a child for whom legal adoption proceedings have been started).
 - Any other child who is related to the Employee without regard to the fact that:
 - The child does not reside with the Employee.
 - The child was born out of wedlock.
 - The child is not claimed as a dependent on the Employee's federal income tax return.
 - The child lives outside the Plan's service area.

If coverage for a dependent child is mandated by a court or administrative order, the child is to be enrolled for coverage without regard to enrollment season.

If the noncustodial parent is the only parent with coverage and is covered under this Plan, the Company will help the custodial parent to enroll the child and to make claims on behalf of that child. Claims will be paid directly to the custodial parent, the provider, or the Arizona health care cost containment system.

A parent may not terminate the child's coverage until written evidence proves one of the following:

- Any court or administrative order providing for the health care coverage of the child is no longer in effect.
 - The child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of such disenrollment.
- Coverage of an adopted child applies regardless of the age at which the child is adopted.

Even if the Employee is not enrolled for Dependents coverage, the health benefits of the Group Plan are payable for 31 days for the Employee's newly adopted child, or to a child who has been placed for adoption with the Employee and for whom the application and approval procedures for adoption have been completed.

The Employee must file a written request with the Employer for payroll deduction to make contributions for Dependents coverage during the first 31 days in order to have the child covered under the Group Plan after that period of time.

If the Employee does not file a written request with the Employer for payroll deduction to make contributions for Dependents coverage during those first 31 days, benefits will no longer be payable for the child after the first 31 days following the date of the child's adoption. In this case, no payment will be made for any day of confinement, treatment, services or supplies given to the child after the initial 31 days. No other benefit or provision of the Plan will apply to the child. This includes but is not limited to the following provisions:

- Extension of benefits.
 - Continuation of coverage.
- Coverage for a mentally or physically handicapped child will not stop due to age. It will continue as long as Dependents coverage continues and the child continues to meet the following conditions:
 - The child is handicapped.
 - The child is not capable of self-support.

- The child depends mainly on the Employee for support.

Proof that the child meets these conditions must be given to the Company when requested. The Company will not ask for proof more than once a year.

Extended Benefits

If the Plan contains a limitation which states that extended benefits are not payable if the benefits are payable under any other group plan, it does not apply.

If a person is Totally Disabled when coverage stops **because the Plan stops**, benefits are payable for up to 12 months after the date coverage stops. The person must be Totally Disabled due to the same cause for the entire time from when coverage stops until charges are made. Benefits are payable only for Covered Expenses charged for the Sickness which caused the Total Disability.

Hospital

The term "**Hospital**" when used in connection with a mental or nervous disorder, alcoholism or drug abuse will be deemed to include an institution which is licensed as a psychiatric hospital by the appropriate authority.

Medicare - Part B Benefits

If the Certificate contains a provision which states that the amount payable under Medicare is determined as the amount that would have been payable to a Medicare eligible even if the person is not enrolled for Medicare Parts A and B, it does not apply. Medicare Part B benefits will be considered under this Plan only if the person is actually covered under Part B.

Reinstatement of Health Coverage

When coverage under the Plan ends because an Employee is ordered into active service in the United States Armed Forces on or after August 22, 1990, the Employee may again be covered under the Plan if:

- The Employee returns to active full-time employment with the Employee's former Employer.
- The Employee makes a written request of reinstatement with the Company within:
 - 90 days of discharge from active service.
 - One year following hospitalization which continued after discharge from active service.

Coverage under the Plan will start on the date determined by Maricopa County subject to State and Federal Statutes.

If the Plan has a waiting period, the Employee will not be required to complete this period a second time.

Each of the Employee's Dependents will also be reinstated for coverage under the Plan on the date the Employee's coverage begins again under the Plan.

Utilization Review: Emergency Care

In the event a Covered Person needs Emergency Care, coverage is provided for Clinically Necessary care and treatment, subject to applicable copayments, coinsurance, and deductibles. The Plan will not deny a claim on the basis that the service was not Clinically Necessary without the review by a Physician of the Plan's choosing.

The Covered Person does not need to call United Behavioral Health (UBH) for authorization of
Maricopa County AZ State Amendment
July 12, 2002

*** Changes to this document are subject to the approval of the Arizona Department of Insurance ***

emergency services.

When the Emergency Care has ended, however, UBH must be called before additional services are received. Benefits are payable for additional Covered Services whether or not UBH is called. Benefits for inpatient confinement and certain outpatient services as described in the Certificate are subject to the Non-Notification Deductible if UBH is not called as soon as reasonably possible.

UNITED HEALTHCARE INSURANCE COMPANY

Ronald Colby

President & CFO

**UNITED BEHAVIORAL HEALTH, 425 MARKET STREET SUITE #2700, SAN FRANCISCO, CA
94105-2426**

PRICING STEET S063202

Terms: NET 30

Vendor Number: **W000000468 X**

Telephone Number: ~~503/274-4631~~ **713/48-8861**

Fax Number: ~~503/274-4633~~ **713/871-3227**

Company Web Site: www.ubhnet.com

E-Mail Address (REP) kay_p_hall@uhc.com sharon_fusco@uhc.com

Contact Person: ~~Key Hall~~ **Sharon Fusco**

Certificates of Insurance Required

Contract Period: To cover the period ending ~~December 31, 2003-2004-2005~~
June 30, 2007.